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THE QUESTION REMAINS: ARE THERE TERMINALLY ILL PATIENTS WHO HAVE A CONSTITUTIONAL RIGHT TO PHYSICIAN ASSISTANCE IN HASTENING THE DYING PROCESS

*Donald H.J. Hermann**

The United States Supreme Court can use various formally recognized devices to avoid making constitutional pronouncements; these include aspects of justiciability¹ such as lack of standing² or ripeness³ and mootness,⁴ or doctrines of judicial restraint such as the political question doctrine.⁵ Sometimes the Court uses rhetorical devices, which often use procedural aspects of a case, to avoid reaching a decision on a

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¹Justiciability doctrines determine which matters the Supreme Court will hear and decide and which must be dismissed to (1) conserve judicial resources, (2) limit the power of the judiciary, (3) improve judicial decision-making, and (4) promote fairness. ERWIN CHERMERINSKY, *FEDERAL JURISDICTION* § 2.1 at 42-45 (2d ed. 1994); *see e.g.*, *Warth v. Seldin*, 422 U.S. 490 (1975); *Flast v. Cohen*, 392 U.S. 83 (1968).

²Whether the specific person is the proper party to bring a particular matter before the Court for adjudication. CHERMERINSKY, *supra* note 1, § 2.3 at 53; *see Warth*, 422 U.S. at 493 ("standing is whether the litigant is entitled to have the court decide the merits of the dispute or a particular set of issues.").

³The Court seeks to avoid matters that are premature for review because the injury is speculative and may never occur. CHERMERINSKY, *supra* note 1, § 2.4 at 113-14; *see Abbot Laboratories v. Gardner*, 387 U.S. 136, 148 (1967).

⁴The mootness doctrine ensures the Court decides an actual controversy in which a dispute remains between the parties. CHERMERINSKY, *supra* note 1, § 2.5 at 125; *see United States Parole Comm. v. Geraghty*, 445 U.S. 388 (1980).

⁵Using the political question doctrine, the Court will dismiss a case, even though a Constitutional violation is alleged, and leave the question to the political process for resolution. CHERMERINSKY, *supra* note 1, § 2.6 at 142; *see Baker v. Carr*, 396 U.S. 186, 217 (1962).

constitutional question such as addressing an issue different from the one primarily raised by the litigants before the court. This latter approach was used by the Court at the end of its 1997 spring term when faced with the claim that competent terminally-ill patients have a constitutional right to physician assistance in hastening the dying process.⁶

THE SCOPE OF THE COURT'S DECISION

As a result of grants of certiorari, the Court had before it opinions from the United States Courts of Appeals for the Second⁷ and Ninth Circuits.⁸ Litigants in the underlying cases claimed a constitutional right for terminally-ill patients to physician assistance in hastening the dying process.⁹ Both appellate courts found a constitutional basis for recognizing this claim.¹⁰

⁶*Quill v. Vacco*, 80 F.3d 716, 731 (2nd Cir. 1996) ("[t]he New York statutes criminalizing assisted suicide violate the Equal Protection Clause, because to the extent that they prohibit a physician from prescribing medications to be self-administered by a mentally competent, terminally-ill person in the final stages of his terminal illness, they are not rationally related to any legitimate state interest."); *Compassion in Dying v. Washington*, 79 F.3d 790, 793-794 (9th Cir. 1996) (*en banc*) ("[w]e hold that insofar as the Washington statute prohibits physicians from prescribing life-ending medications for use by terminally-ill, competent adults who wish to hasten their own deaths, it violates the Due Process Clause of the Fourteenth Amendment.")

⁷*Quill v. Koppell*, 870 F. Supp. 78 (S.D.N.Y. 1994), *rev'd sub. nom.*, *Quill v. Vacco*, 80 F.3d 716 (2d cir. 1996), *cert. granted*, *Vacco v. Quill*, 117 S. Ct. 2293 (1996).

⁸*Compassion in Dying v. Washington*, 850 F. Supp. 1454 (W.D. Wash. 1994), *rev'd*, *Compassion in Dying v. Washington*, 49 F.3d 586 (9th Cir. 1995), *aff'd*, *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996) (*en banc*), *cert. granted sub nom.*, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1996).

⁹*See* *Compassion in Dying v. Washington*, 79 F.3d 790, 793 (9th Cir. 1996) (*en banc*) ("[t]oday, we are required to decide whether a person who is terminally-ill has a constitutionally-protected liberty interest in hastening ... death."); *Quill v. Vacco*, 80 F.3d 716, 718 (2nd Cir. 1996) ("[t]he physicians contend that each statute is invalid to the extent that it prohibits them from acceding to the requests of terminally-ill, mentally competent patients for help in hastening death.")

¹⁰*Quill*, 80 F.3d at 727 ("the statutes [criminalizing physician-assisted suicide] lack any rational basis and are relative of the Equal Protection Clause."); *Compassion in Dying*, 79 F.3d at 838 ("[w]e hold that a liberty interest exists in the choice of how and when one dies, and that the provision of the Washington statute banning assisted suicide, as applied to competent, terminally-ill adults who wish to hasten their deaths ... violates the Due Process Clause.").

In *Compassion in Dying v. State of Washington*, decided by a majority of the Ninth Circuit after *en banc* review, the court held that to the extent the Washington statute prohibits physicians from prescribing life-ending medication for use by terminally-ill, competent adults who wish to hasten their own deaths, the Washington statute violated the Due Process Clause of the Fourteenth Amendment.¹¹ A close reading of the holding reveals the Court narrowly tailored its decision to meet the situation of "terminally ill" competent patients who wish to "hasten their own death."

Similarly, in *Quill v. Vacco*, the Second Circuit was asked to declare unconstitutional two New York statutes penalizing assistance in suicide to the extent the statutes prohibit physicians from meeting requests of terminally-ill, mentally competent patients for drugs to hasten death.¹² The Second Circuit decided without dissent, that to the extent the New York statutes criminalizing assisted suicide prohibited a physician from prescribing medications to be self-administered by a mentally competent, terminally-ill person in the final stages of the patient's terminal illness, the statutes were not related to any legitimate state interest and violated the Equal Protection Clause.¹³ As was the case with the Ninth Circuit's opinion, the Second Circuit narrowly tailored its holding to answer the question of whether terminally-ill patients have the right to assistance in hastening their death.¹⁴

Rather than address the narrow question posed by the opinion of the Ninth Circuit, a majority of the Supreme Court, in an opinion written by Chief Justice Rehnquist, accepted the formulation presented by the petitioner, the State of Washington in the *Glucksberg* case, that cast the question presented to be whether the Washington statute prohibiting the causing or aiding of the suicide of another violated the Fourteenth

¹¹*Compassion in Dying*, 79 F.3d at 838; WASH. REV. CODE § 9A.36.060 ("[a] person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide.").

¹²*Quill*, 80 F.3d at 719; N.Y. PENAL LAW §125.15 ("[a] person is guilty of manslaughter in the second degree then: ... [h]e intentionally ... aids another person to commit suicide."); N.Y. PENAL LAW § 120.30 ("[a] person is guilty of promoting a suicide attempt when he intentionally ... aids another person to attempt suicide.").

¹³*Quill*, 80 F.3d at 727.

¹⁴*Quill v. Vacco*, 80 F.3d 716, 732 (2d Cir. 1996).

Amendment of the United States Constitution.¹⁵ Similarly, in his opinion in *Vacco v. Quill*, Chief Justice Rehnquist formulated the issue before the Court to be the question of whether the New York statute prohibiting assisting suicide violated the Equal Protection Clause of the Fourteenth Amendment.¹⁶ Posed this way, the issue before the Court far exceeded the narrow holding of the Second Circuit. Thus, the Chief Justice presented the broad question of the constitutionality of state criminal law prohibitions of assisting a suicide; rather than the narrower question of whether physician-assisted suicide, in the case of terminal patients, is distinguishable from the Court endorsed practice of acceding to a patient's request for withholding or withdrawing of treatment, including nutrition and hydration. The Chief Justice suggested his reason for formulating the issue more broadly than the Court of Appeals, is his view that it is not possible to limit the availability of assistance in suicide to the class of competent terminally-ill patients. Instead, the Chief Justice maintained that "what is couched as a limited right to 'physician-assisted suicide' is likely to effect, a much broader license, which could prove extremely difficult to police and contain."¹⁷ This slippery slope argument which the Chief Justice suggests may lead from "assisted suicide" to "euthanasia" is certainly debatable, but seldom does such an argument weigh heavily against a claim of constitutional right.¹⁸ Instead, the Court often sets out limits for the

¹⁵*Washington v. Glucksberg*, 117 S. Ct. 2258, 2261 (1997).

¹⁶*Vacco v. Quill*, 117 S. Ct. 2293, 2296 (1997).

¹⁷*Glucksberg*, 117 S. Ct. at 2274.

¹⁸*Id.* at 2275-76. *But see* *Griswold et al. v. Connecticut*, 381 U.S. 479, 85 S. Ct. 1678, 142 L.Ed. 2d 510 (1965) where the United States struck down the 1879 Connecticut law prohibiting the sale or use of contraceptives on the basis that this law operated directly on the intimate relation of husband and wife and their physician's role in one respect of that relation. The Court made its decision despite the argument that its holding could not be limited to married couples, but would inevitably be extended to unmarried persons. Of course, the Court was correct in its holding and the critics were correct in their prediction. In *Eisenstadt v. Baird*, 405 U.S. 438, 92 S. Ct. 1029, 31 L.Ed. 3d 349 (1972), the Court determined there was no basis for rationally distinguishing treatment accorded married and unmarried persons under the state statute regulation physicians administering or prescribing drugs or articles intended for the prevention of pregnancy or contraception.

exercise of rights such as it did in the abortion cases, first with its trimester analysis¹⁹ and now with its pre- and post-viability analysis.²⁰

A careful reading of the opinions rendered by the various Justices in these cases makes it clear none of the Justices expressed the position that the Court's opinions in *Washington v. Glucksberg* or *Vacco v. Quill* provide a final answer to whether there is a right to physician assistance for a terminal patient wishing to hasten the dying process under all circumstances. Even Chief Justice Rehnquist carves out space for a possible claim to such a right. In footnote 24 of his opinion, the Chief Justice expressed agreement with the view expressed by Justice Stevens that the Court's opinion does "not foreclose the possibility that an individual seeking to hasten her death, or a doctor where assistance was sought, could prevail in a more particularized challenge"; affirmatively, the Chief Justice stated "[o]ur opinion does not absolutely foreclose such a claim."²¹

THE CONCURRING OPINIONS LEAVE OPEN THE QUESTION OF PHYSICIAN-ASSISTED SUICIDE

Justice Stevens is very clear in his recognition of the possibility of a future Court ruling recognizing the right of a terminally-ill patient to physician assistance in hastening death. Justice Stevens stated: "I write separately to make it clear that there is also room for further debate about the limits that the Constitution places on the power of the States to punish the practice [of physician-assisted suicide]."²² According to Justice Stevens, the Court's opinion in *Washington v. Glucksberg* does nothing more than determine that the Washington statute prohibiting assisted suicide is not invalid "on its face"; meaning the statute is constitutional in most of the situations where it might be applied. However, he points out "[t]hat

¹⁹Roe v. Wade, 410 U.S. 113, 93 S. Ct. 705, 35 L.Ed. 2d 147 (1973).

²⁰See *Planned Parenthood of Southern Pennsylvania v. Casey*, 505 U.S. 833, 112 S. Ct. 2791, 120 L.Ed. 2d 674 (1992).

²¹*Glucksberg*, 117 S. Ct. at 2274 n.24 (emphasis added).

²²*Washington v. Glucksberg*, 117 S. Ct. 2302, 2304 (1997) (separate concurring opinions for both *Washington v. Glucksberg* and *Vacco v. Quill*) (Stevens, J., concurring).

holding, however, does not foreclose the possibility that some application of the statute might well be invalid."²³

Unlike the Chief Justice's opinion which simply adopted the posture that the Court had before it a facial challenge to the constitutionality of Washington's criminal statute forbidding assistance to facilitate a suicide, Justice Stevens' concurring opinion explained the procedural developments in the case that convinced him to treat the matter as a facial challenge, rather than a challenge to the application of the statute to the situation of competent terminally-ill patients wishing to hasten the dying process. Justice Stevens explained:

As originally filed, this case presented a challenge to the Washington statute on its face and as it applied to three terminally-ill, mentally competent patients and to four physicians who treat terminally-ill patients. After the District Court issued its opinion, holding that the statute placed an undue burden on the right to commit physician-assisted suicide, the three patients died. Although the Court of Appeals considered the constitutionality of the statute "as applied to the prescription of life-ending medication for use by terminally-ill, competent adult patients who wish to hasten their deaths," the court did not have before it any individual plaintiff seeking to hasten her death or any doctor who was threatened with prosecution for assisting in the suicide of a particular patient; its analysis and eventual holding that the statute was unconstitutional was not limited to a particular set of plaintiffs before it. [Citations omitted].²⁴

The procedural posture of the case, according to Justice Stevens, allowed the Court to treat the case as one involving a facial challenge to Washington's criminal statute "addressing not the application of the statute to a particular set of plaintiffs before it, but the constitutionality of the

²³*Id.* at 2304 [Emphasis added].

²⁴*Id.* (quoting the majority opinion of Rehnquist, J.). Rather than reformulating the question presented by the appeals court opinions, the Court could have invoked doctrines of mootness or lack of standing. See text and accompanying footnotes 2 and 4.

state's categorical prohibition against 'aid[ing] another person to attempt suicide.'"²⁵

Formulating the case as one involving a facial challenge increased the level of the showing required by respondents necessary to establish the unconstitutionality of the Washington statute. According to Justice Stevens, by formulating the question before the Court in this manner, it becomes necessary for "the plaintiffs to show that the interest in liberty protected by the Fourteenth Amendment 'includes a right to commit suicide which itself includes a right to assistance in doing so.'"²⁶

Justice Stevens readily agreed in his opinion, concurring in the judgment of the Court, that there is no basis in law supporting an open-ended constitutional right to assistance in committing suicide. Nevertheless, Justice Stevens made it clear a finding that the liberty protected by the Due Process Clause does not include a categorical "right to commit suicide, which itself includes a right to assistance in doing so," and thus, does not reach "the narrow question of the right of a terminally-ill competent patient to assistance in hastening the dying process."²⁷ On the contrary, Justice Stevens wrote: "[T]here are situations in which an interest in hastening death is legitimate. Indeed, not only is that interest sometimes legitimate, *I am also convinced that there are times which it is entitled to constitutional protection.*"²⁸

Justice Stevens suggests there may be differences among terminally-ill patients as members of a class permitting some, but precluding others, from making a claim to a constitutional right to physician assistance in hastening death. Justice Stevens asserts that "I would not say as a categorical matter that these state interests are invalid as to the entire class of terminally-ill, mentally competent patients. I do not, however, foreclose the possibility that an individual plaintiff seeking to hasten her death, or a doctor whose assistance was sought, could prevail in a more particularized challenge."²⁹

²⁵*Id.* at 2305 (separate concurring opinions for both *Washington v. Glucksberg* and *Vacco v. Quill*)(Stevens, J., concurring).

²⁶*Id.*

²⁷*Washington v. Glucksberg*, 117 S. Ct. 2302, 2305 (1997).

²⁸*Id.* [Emphasis added].

²⁹*Id.* at 2309.

Justice Stevens suggests that a proper consideration of the Court's opinions should result in a narrow reading of their holdings. Justice Stevens provides such a narrow reading when he concludes that in *Vacco v. Quill* the Court holds that the Equal Protection Clause is not violated by the New York's classification, just as its holding in *Washington v. Glucksberg* that the Washington statute is not invalid on its face, does not foreclose the possibility that some applications of the New York statute may impose an intolerable intrusion on a patient's freedom.³⁰

Justice Breyer suggests the formulation of the issue adopted in the Court's opinion leaves open the question whether a terminally-ill competent patient may, under certain circumstances, claim a constitutional right to physician assistance in hastening the dying process. Justice Breyer would not limit the issue to the question whether there is a liberty interest in "physician-assisted suicide,"; on the contrary, he writes "I would not reject the respondents' claim without considering a different formulation, for which our legal tradition may provide greater support. This formulation would use words roughly like a '*right to die with dignity*.'"³¹ Justice Breyer goes on to identify three personal interests which may be at stake in the "right to die with dignity": personal control by the individual over the manner of one's dying; a right to professional medical assistance in hastening death; and the avoidance of unnecessary physical pain and suffering.³²

One circumstance of a terminal competent patient that Justice Breyer suggests may be sufficient to establish the basis for a claim to a constitutional right to physician assistance in hastening the dying process would be *persistent, unrelievable, physical pain and suffering*. According to Justice Breyer, "the avoidance of severe physical pain (connected with death) would have to comprise an essential part of any successful claim."³³

³⁰*Id.* at 2310.

³¹*Id.* at 2311 (separate concurring opinions for both *Washington v. Glucksberg* and *Vacco v. Quill*) (Breyer, J., concurring). [Emphasis added].

³²*Washington v. Glucksberg*, 117 S. Ct. 2302, 2311 (1997) (citing concurring opinion of O'Connor, J.); *see Washington v. Glucksberg*, 117 S. Ct. 2302, 2303 (1997) (separate concurring opinions for both *Washington v. Glucksberg* and *Vacco v. Quill*) (O'Connor, J., concurring).

³³*Id.* at 2311 (separate concurring opinions for both *Washington v. Glucksberg* and *Vacco v. Quill*) (Breyer, J., concurring).

Citing the opinion of Justice O'Connor, Justice Breyer reiterates the observation that the laws of Washington and New York that were before the Court do not prohibit physicians from providing terminally-ill patients with drugs sufficient to control pain despite the risk these drugs will hasten the dying process, or in Justice Breyer's words: "*despite the risk that those drugs themselves will kill.*"³⁴

Justice O'Connor clearly states that she joined the Court's opinion "[b]ecause I agree that there is no generalized right to 'commit suicide.'"³⁵ On the other hand, Justice O'Connor expresses concern for the pain and suffering experienced by some dying persons. She writes: "For many, the last days will be spent in physical pain and perhaps [with] the despair that accompanies physical deterioration and a loss of control of basic bodily and mental functions. Some will seek medication to alleviate that pain and other symptoms."³⁶

Justice O'Connor does not accept Justice Breyer's formulation of the issue before the Court as involving the issue of the "right to die with dignity." Specifically, Justice O'Connor rejects the respondent's formulation of the question as "whether a mentally competent person who is experiencing great suffering has a constitutional interest in controlling the circumstances of his or her imminent death."³⁷ Instead, Justice O'Connor would state the issue to be "[t]he question whether suffering patients have a constitutionally cognizable interest in obtaining relief from the suffering that they may experience in the last days of their lives."³⁸

After formulating the question at issue as whether competent terminally-ill patients experiencing *unrelievable pain and suffering* have a constitutional right to physician assistance in relieving that pain by hastening death, Justice O'Connor finds no need to address the question. Because the cases before the Court did not involve patients who meet the qualifying constraints posed by her formulation of the question, Justice

³⁴*Id.* at 2311 (citing Justice O'Connor's concurring opinion at 2303). [Emphasis added].

³⁵*Id.* at 2303 (separate concurring opinions for both Washington v. Glucksberg and Vacco v. Quill (O'Connor, J., concurring)).

³⁶*Id.*

³⁷Washington v. Glucksberg, 117 S. Ct. 2302, 2305 (1997) (separate concurring opinions for both Washington v. Glucksberg and Vacco v. Quill (O'Connor, J., concurring)).

³⁸*Id.*

O'Connor avoided the constitutional question altogether. Justice O'Connor points out that the state laws under review provide that "a patient who is suffering from a terminal illness and who is experiencing great pain has *no legal barriers to obtaining medication, from qualified physicians, to alleviate that suffering, even to the point of causing unconsciousness and hastening death.*"³⁹

Justice O'Connor emphasized the need for state laws to be written to strike a proper balance between the interests of terminally-ill, mentally competent individuals who wish to seek physician assistance in ending their suffering and the state's interests in protecting those who might otherwise be pressured or misled to end their lives.⁴⁰

Justice Breyer expresses his shared view with Justice O'Connor, noting the need for laws to accommodate the competent, terminally-ill, suffering patient. Justice Breyer goes on specifically to suggest that if state laws do not properly accommodate such patients' interests, these laws risk being found constitutionally flawed.⁴¹ While agreeing that neither the Washington nor New York statutes, on their face, preclude a physician from providing medication to relieve a terminally-ill patient's suffering to the point of causing unconsciousness and hastening death, Justice Breyer suggests that were these laws to the contrary, his view of the constitutionality would differ. Justice Breyer explicitly agreed with Justice O'Connor that if it can be shown that a state's law does not permit "the provision of palliative care, including the administration of drugs as needed to avoid pain at the end of life -- then the law's impact upon serious and otherwise unavoidable physical pain (accompanying death) would be more directly at issue"; and the Court would need "to revisit its conclusion in these cases."⁴²

³⁹*Id.* at 2303. [Emphasis added.]

⁴⁰*Id.*

⁴¹*Id.* at 2310-2311 (1997) (separate concurring opinions both *Washington v. Glucksberg* and *Vacco v. Quill*) (Breyer, J., concurring).

⁴²*Washington v. Glucksberg*, 117 S. Ct. 2302, 2310-2312 (1997); *see* WASH. REV. CODE §§ 9A.36.060(1) (1994), *construed in* *Washington v. Glucksberg*, 117 S. Ct. 2258, 2261 (1997) ("[a] person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide."); WASH. REV. CODE §§ 9A.36.060(1)(c), (2) (1994), *construed in* *Washington v. Glucksberg*, 117 S. Ct. 2258, 2261 (1997) ("[p]romoting a suicide attempt' is a felony, punishable by up to five years' imprisonment and up to a \$10,000 fine).

Justice Souter, perhaps, provided the most compelling explanation for the Court's avoidance of the narrow question of a competent terminally-ill patient's right to physician assistance in hastening the dying process. He suggested uncertainty in how such a right would be implemented and expressed fear that judicial recognition of such a broad right, without carefully tailored regulatory legislation, would lead to involuntary euthanasia and other abuses.⁴³ If the law is to recognize the broad claim made by respondents, Justice Souter expressed his preference that state legislatures formulate standards and procedures to accommodate valid patient interests while protecting vulnerable persons who might be coerced into physician-assisted death.⁴⁴ However, even Justice Souter suggests the possible future recognition of a terminally-ill patient's constitutional right to physician assistance in hastening the dying process.

Justice Souter concluded his opinion with the suggestion that the Court has actually deferred the decision on the question of whether a competent terminally-ill patient under certain circumstances has a constitutional right to physician assistance in hastening the dying process in order to allow state legislative efforts to craft appropriate statutory law on the matter.⁴⁵ According to Justice Souter: "The Court should accordingly stay its hand to allow reasonable legislative consideration. *While I do not abide for all time that respondents' claim should not be*

⁴³Washington v. Glucksberg, 117 S. Ct. 2258, 2290-2291 (1997) (Souter, J., concurring)..

⁴⁴*Id.* at 2293.

⁴⁵*Id.* A previous example of the Court deferring final judgment on a constitutional claim is the Court's decision in *Powell v. Texas*, 392 U.S. 514, 88 S. Ct. 2145, 20 L.Ed. 2d 1254 (1968) where the Court had before it the question of whether a criminal conviction of a person being found in a state of intoxication in a public place violated the Cruel and Unusual Punishment Clause of the Eighth Amendment. While the Court expressed sympathy for the view that chronic alcoholism was a disease and not properly a matter for criminal punishment, the Court reluctantly refused to strike down state laws punishing public drunkenness. Justice Black's concurring opinion sounds a note strikingly similar to that sounded by several of the Justices in their opinions in the physician-assisted suicide cases. Justice Black wrote: "To adopt this position [striking down the state statutes] would significantly limit the States in their efforts to deal with a widespread and important-social problem and would do so by announcing a revolutionary doctrine of constitutional law that would also tightly restrict state power to deal with a wide variety of other harmful conditions." *Id.* at 2166-67.

recognized, I acknowledge the legislative institutional competence as the better one to deal with that claim at this time."⁴⁶

JUSTICE REHNQUIST'S REJECTION OF THE CLAIM TO A FUNDAMENTAL RIGHT TO ASSISTED SUICIDE

In his opinion for the Court, Chief Justice Rehnquist had little difficulty finding that the Due Process Clause of the Constitution does not provide the basis for the claim of a constitutionally protected interest in receiving or providing assistance in suicide. According to the Chief Justice, there is nothing in our Nation's history, legal traditions, or practices that provide any basis for a general right to assistance in suicide.⁴⁷ All but two states make it a crime to assist a suicide; and according to Chief Justice Rehnquist, almost every western democracy makes it a crime to assist a suicide.⁴⁸ Citing treatise writers such as Bracton⁴⁹ and Blackstone,⁵⁰ the Chief Justice maintained that for over 700 years, the Anglo-American common-law tradition punished or otherwise disapproved of both suicide and assisting suicide.⁵¹ While the early American colonies provided harsh penalties including criminal forfeitures and sanctions for suicide, the movement away from such penalties was not because suicide became condoned. Rather, according to Chief Justice Rehnquist, the courts

⁴⁶*Id.* at 2293. [Emphasis added.]

⁴⁷*Id.* at 2263-2264.

⁴⁸*Washington v. Glucksberg*, 117 S. Ct. at 2263 (citing *Compassion in Dying v. Washington*, 79 F.3d 790, 847 and nn.10-13 (9th Cir. 1996) (Beezer, J., dissenting) ("[i]n total, forty-four states, the District of Columbia and two territories prohibit or condemn assisted suicide ...") (citing statutes and cases); *Rodriguez v. British Columbia (Attorney General)*, 107 D.L.R. (4th) 342, 404 (Can. 1993) ("a blanket prohibition on assisted suicide ... is the norm among western democracies ...") (discussing assisted-suicide provisions in Austria, Spain, Italy, the United Kingdom, the Netherlands, Denmark, Switzerland, and France). Since the Ninth Circuit's decision, Louisiana, Rhode Island, and Iowa have enacted statutory assisted-suicide bans. LA. REV. STAT. ANN. § 14:32.12 (Supp. 1997); R.I. GEN. LAWS § 11-60-1, 11-60-3 (Supp. 1994); IOWA CODE ANN. § 707a.2, 707a.3 (Supp. 1997).

⁴⁹2 BRACTON ON LAWS AND CUSTOMS OF ENGLAND 423 (f. 150) (G. Woodbine ed., S. Thorne transl., 1968), *cited in*, *Glucksberg*, 117 S. Ct. at 2263.

⁵⁰4 W. BLACKSTONE, COMMENTARIES *189, *cited in*, *Glucksberg*, 117 S. Ct. at 2263; *Glucksberg*, 117 S. Ct. at 2264.

⁵¹*Glucksberg*, 117 S. Ct. at 2263-64.

continued to condemn suicide as a grave public offense, but simply came to the conclusion that it was unfair to punish a the family of a person who committed suicide for the person's wrongdoing.⁵²

Early state laws prohibited suicide and made anyone who assisted suicide subject to the charge of murder as a principal offender.⁵³ The consent of the person committing suicide was wholly immaterial in determining the guilt of the person charged with homicide.⁵⁴ Not according to the Chief Justice, was there any exception for the terminally ill.⁵⁵ In 1828, New York adopted the first state statute explicitly outlawing assisting suicide.⁵⁶ At the time of ratification of the Fourteenth Amendment, Chief Justice Rehnquist noted, most states had made it a crime to assist a suicide.⁵⁷

While some commentators see physician-assisted suicide as a logical extension of recent legal recognition of living wills, surrogate decision making for health care, and provisions for withdrawal or withholding of life-sustaining medical treatment, the Chief Justice disagrees.⁵⁸ According to Chief Justice Rehnquist, the very fact of the legal recognition of the end-of-life measures invokes an explicit rejection of physician-assisted suicide. Chief Justice Rehnquist cites several states' legislative experience with this subject; specifically he refers to the history of the Washington legislation on withdrawal and withholding of treatment:

The Washington statute at issue in the case, WASH. REV. CODE § 9A.36.060 (1994) was enacted in 1975 as part of a revision of that state's criminal code. Four years later, Washington passed its Natural Death Act, which specifically stated that the "withholding or withdrawal of life-sustaining treatment ... shall not, for any

⁵²*Id.* at 2265 (citing MODEL PENAL CODE § 210.5, Comment 5, p. 100 (Official Draft and Revised Comments 1980)).

⁵³*Id.*

⁵⁴*Id.* (citing MODEL PENAL CODE § 210.5, Comment 5, p. 100 (Official Draft and Revised Comments 1980)).

⁵⁵*Id.*

⁵⁶*Washington v. Glucksberg*, 117 S. Ct. 2258, 2265 (1997).

⁵⁷*Id.*

⁵⁸*Id.* at 2265-66; see also Note, *Physician-Assisted Suicide and the Right to Die with Assistance*, 105 Harv. L. Rev. 2021, 2040 (1992) ("[p]hysician-assisted suicide is not fundamentally different from the withholding of medical treatment").

purpose, constitute a suicide" and that "[n]othing in this chapter shall be construed to condone, authorize, or approve mercy killing" Natural Death Act, 1979 WASH. LAWS, ch. 112, §§ 8(1), p. 1 (codified at WASH. REV. CODE §§ 70.122.070 (1), 70.122.100 (1994)). In 1991, Washington voters rejected a ballot initiative which, had it passed, would have permitted a form of physician assisted suicide. Washington then added a provision to the Natural Death Act expressly excluding physician-assisted suicide. 1992 WASH. LAWS, ch. 98, § 10; WASH. REV. CODE § 70.122.100 (1994).⁵⁹

While it could be argued that the 1994 successful ballot initiative in Oregon, the "Death With Dignity Act" legalizing physician-assisted suicide for competent, terminally-ill adults, reflects a growing social acceptance of physician-assisted suicide, the Chief Justice again holds a contrary view.⁶⁰ Chief Justice Rehnquist minimizes the significance of the Oregon Initiative by countering it with the fact that no state legislature has adopted a proposal to legalize assisted suicide. In fact, Chief Justice Rehnquist points out that two states recently adopted statutes explicitly prohibiting assisted suicide; moreover, Congress passed the Federal Assisted Suicide Funding Restriction Act in 1977 prohibiting the use of federal funds to support physician-assisted suicide.⁶¹ For the Chief Justice, the only positive significance of the Oregon Initiative is that it exemplifies state activity

⁵⁹Glucksberg, 117 S. Ct. at 2266.

⁶⁰*Id.* at 2266. Timothy Egan, *Assisted Suicide Comes Full Circle, to Oregon*, N.Y. TIMES, Oct. 26, 1997 at A1. It should be noted that the Oregon law was itself the subject of protracted litigation. *Lee v. Oregon*, 107 F.3d 1382 (9th Cir. 1997), *rev'g* *Lee v. Oregon*, 891 F. Supp. 1429 (D. Ore. 1995), *Lee v. Oregon*, 891 F. Supp. 1439 (D. Ore. 1995), *cert. denied* *Lee v. Hareleroad*, No. 96-1824, 1997, WL 274930 (U.S. Oct. 14, 1997). Even though the Oregon initiative passed, the Oregon legislature resubmitted the matter to the Oregon voters in the fall of 1997. It should be noted that the initial voter initiative in Oregon in 1994 passed by 51 percent to 49 percent. The law submitted to the voters in 1997 authorizing physician-assisted suicide received an approval vote by 60 percent of the voters. *See Right to Die: In Oregon, Opening a New Front in the World of Medicine*, N.Y. TIMES, November 6, 1997, p. A22, col. 1. *See also* J. Graham & J. Peres, *Assisted-Suicide Door Opens Wide*, CHGO TRIB., November 6, 1997, sec. 1, p. 1, col. 2 and p. 27, col. 1.

⁶¹*Id.* at 2266 citing IOWA CODE ANN. §§ 707A.2, (Supp. 1997); R.I. GEN. LAWS §§ 11-60-1, 11-60-3 (Suppl 1996) and PUB. L. 105-12, 111 Stat. 23 (codified at 42 U.S.C. § 14401).

addressing the issue of physician-assisted suicide in the proper political forum, rather than in the federal courts.⁶²

As one familiar with the Court's opinions over the last decade might expect, there is no mention of the right of privacy as a relevant factor in Justice Rehnquist's opinion.⁶³ Instead the Chief Justice considers the question before the Court with reference solely to the liberty interests protected by the Due Process Clause.

Citing *Cruzan v. Director, Missouri Dep't of Health*, the Chief Justice observes: "We have also assumed, and strongly suggested, that the Due Process Clause protects the traditional right to refuse unwanted lifesaving medical treatment."⁶⁴ Yet, the Chief Justice expresses his usual strong reluctance to expanding the "concept of substantive due process" by recognizing a new "asserted right or liberty interest" because: (1) judicial recognition of a claimed right places the underlying issue outside the arena of public debate and legislative action; and (2) the Court should refuse to transform the policy preferences of the Justices into newly recognized constitutional rights.⁶⁵

The Chief Justice takes issue with the position of Justice Souter who would ask "whether [Washington's] statute sets up one of those 'arbitrary impositions' or, purposeless restraints' at odds with the Due Process Clause of the Fourteenth Amendment."⁶⁶ According to Justice Rehnquist this approach would be far too open ended and involve the Court in an endless process of balancing competing interests of citizens and state authority. The Chief Justice insists analysis should be directed at the question of whether "a challenged action implicate[s] a fundamental right,"

⁶²*Glucksberg*, 117 S. Ct. at 2266-2667.

⁶³See Anita L. Allen, *Autonomy's Magic Wand: Abortion and Constitutional Interpretation*, 72 B.U.L. REV. 683, 686 (1992); see also *Bowers v. Hardwick*, 478 U.S. 186, 191 (1985) (the court did not use a privacy analysis as one might have expected, instead, the court only held that consensual sodomy between homosexuals was not a fundamental right).

⁶⁴*Glucksberg*, 117 S. Ct. at 2667 (citing *Cruzan v. Director, Mo. Dept. of Health*, 497 U.S. 261, 278-79 (1990)).

⁶⁵*Id.* at 2267-2268.

⁶⁶*Washington v. Glucksberg*, 117 S. Ct. 2302, 2268, 2269 (1997) (citing the opinion of Justice Souter, 117 S. Ct. at 2275 quoting *Poe v. Ullman*, 367 U.S. 497, 543, 81 S. Ct. 1752, 1776-1777 (1961) (Harlan, J., dissenting)).

i.e., a carefully described fundamental right or liberty interest which is objectively “deeply rooted in this Nation’s history and tradition.”⁶⁷

The Chief Justice presents his version of the “‘careful description’ of the respondents’ claim” in these terms: “The question presented in this case, however, is whether the protections of the Due Process Clause include a right to commit suicide with another’s assistance.”⁶⁸ For the litigants in this case, a careful description of their claim may be more properly stated as the right of competent, terminally-ill patients to physician assistance in hastening the dying process. Nevertheless, taking the Chief Justice’s “careful description” of the litigant’s claim, the next step is to “inquire whether this asserted right has any place in our Nation’s traditions.”⁶⁹ The final step is to determine whether the state law prohibiting assisted suicide is rationally related to a legitimate government interest. After a review of the history of the law dealing with suicide, the Chief Justice easily concluded that, rather than finding a recognition of assisted suicide as part of the nation’s legal tradition, there has been an “almost universal tradition that has long rejected the asserted right, and continues to reject it today, even for terminally-ill, mentally competent adults.”⁷⁰

Despite the apparent tight logic of this approach and the easy disposal of the claim to a right to assisted suicide, the Chief Justice, nevertheless, goes on to address previous opinions of the Court cited by proponents of the recognition of a competent terminally-ill patient’s right to assisted suicide, to establish that there is a basis in American law for recognition of such a right. Specifically, the Chief Justice makes a strong effort to distinguish *Cruzan* and to show that the respondents’ understanding of the Court’s opinion in *Cruzan* is flawed. The Chief Justice points out that “for purposes of [that] case, we assume[d] that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.”⁷¹ Justice Rehnquist then proceeds to

⁶⁷*Id.* at 2268.

⁶⁸*Id.* at 2269.

⁶⁹*Id.* at 2270.

⁷⁰*Id.* at 2269-2270.

⁷¹*Washington v. Glucksberg*, 117 S. Ct. 2253, 2270 (citing *Cruzan*, 497 U.S. at 279, 110 S. Ct. at 2852).

provide a very narrow reading of the holding in *Cruzan*, stating, "We concluded that, notwithstanding this [assumed] right, the Constitution permitted Missouri to require clear and convincing evidence of an incompetent patient's wishes concerning the withdrawal of life-sustaining treatment."⁷²

The Chief Justice is adamant in rejecting the respondents' claim that the recognition of the right to physician-assisted suicide is implicit in the *Cruzan* holding. According to Rehnquist, there is no basis in the reasoning or holding in *Cruzan* which supports the view that *Cruzan* "applies at least as strongly to the choice to hasten impending death by consuming lethal medications" as it does to decisions to refuse death delaying treatment.⁷³ Rehnquist rejects even more vehemently the Ninth Circuit's reading of the holding in *Cruzan* that it "necessarily recognize[d] a liberty interest in hastening one's own death."⁷⁴ According to the Chief Justice, the holding in *Cruzan* was based on a "long legal tradition protecting the decision to refuse unwanted medical treatments" while respondents' claim of a right "to commit suicide with the assistance of another ... has never enjoyed similar legal protection."⁷⁵ The Chief Justice also points out that in the *Cruzan* opinion, recognition was given to the fact that most states prohibited assisted suicide. Further, Justice Rehnquist states "we certainly gave no intimation that the right to refuse unwanted medical treatment could be somehow transmuted into a right to assistance in committing suicide."⁷⁶

The Chief Justice also faulted respondents' reliance on *Planned Parenthood v. Casey* in which the Supreme Court affirmed its earlier decision in *Roe v. Wade* holding, in part, that a woman has a right before her fetus is viable to an abortion without interference from the State.⁷⁷ The Ninth Circuit, according to the Chief Justice, misconstrued the language in *Casey* that stated many of the rights and liberties recognized under the Due Process Clause "involv[e] the most intimate and personal choices a

⁷²*Id.* (citing *Cruzan* at 280-281, 110 S. Ct. at 2852-2853).

⁷³*Id.*

⁷⁴*Id.*

⁷⁵*Id.* at 2269-2270.

⁷⁶*Washington v. Glucksberg*, 117 S. Ct. 2258, 2270.

⁷⁷*Id.* (citing *Planned Parenthood v. Casey*, 505 U.S. 833, 846 (1992)).

person may make in a lifetime.”⁷⁸ The Ninth Circuit found this language “almost prescriptive” of the conclusion that “the decision how and where to die is one of the most intimate and personal choices a person may make in a lifetime.”⁷⁹ The respondents also misconstrued the meaning of *Casey*, according to the Chief Justice, when they argued: “[a]t the heart of liberty is the right to define one’s own concept of existence.”⁸⁰ On the contrary, the Chief Justice opines: “That many of the rights and wishes protected by the Due Process Clause sound in personal autonomy does not warrant the sweeping conclusion that any and all important, intimate, and personal decisions are so protected.”⁸¹

The Chief Justice turned his attention to the final step of a Due Process analysis: scrutiny of a state law requiring any regulation to be rationally related to a legitimate government interest.⁸² The Chief Justice identifies what he considers to be four valid state interests in prohibiting physician-assisted suicide:

- (1) The state has an unqualified interest in the preservation of all human life. In pursuing its interest in preserving human life, the state may with good reason properly decline to make judgments about the quality of life that a particular individual may enjoy. Moreover, the state may reasonably assume that recognition of physician-assisted suicide would make it more difficult to protect depressed or mentally ill persons, or those who are suffering from untreated pain, from suicidal impulses.⁸³
- (2) The state has an interest in protecting the integrity and ethics of the medical profession. The state may reasonably act on the assumption that recognizing physician-assisted suicide could undermine the trust essential to the physician-patient relationship.⁸⁴

⁷⁸*Id.* at 2270-2271 (citing *Compassion in Dying v. Washington*, 79 F.3d 790, 813-14 (9th Cir. 1996)).

⁷⁹*Id.* at 2271.

⁸⁰*Id.* at 2271 (citing *Planned Parenthood v. Casey*, 505 U.S. 833, 851 (1992)).

⁸¹*Washington v. Glucksberg*, 117 S. Ct. 2258, 2269-2 at 2272.

⁸²*Id.* at 2271.

⁸³*Id.* at 2272-2273.

⁸⁴*Id.* at 2273.

- (3) The state has an interest in protecting vulnerable groups including the poor, the elderly, and disabled persons. The state may reasonably act on the assumption that physician-assisted suicide poses profound risks to ill and vulnerable persons who are terminally-ill, disabled or elderly including coercion to accept physician-assisted suicide and stigmatization of the ill and dying that may be implicit in a policy that permits physician-assisted suicide.⁸⁵
- (4) The state may properly fear that recognition of physician-assisted suicide will lead to the practice of voluntary and involuntary euthanasia.⁸⁶

In making the case for the validity of these asserted state interests, the Chief Justice places questionable reliance on his interpretation of various published reports and studies concerning matters related to physician-assisted suicide. For example, Justice Rehnquist cites a report of the New York State's Task Force on Life and the Law for the proposition that "Those who attempt suicide - terminally-ill or not - often suffer from depression or other mental disorders."⁸⁷ Justice Rehnquist also cites a report made to a House Subcommittee on the issue of physician-assisted suicide and euthanasia in the Netherlands for the proposition: "[I]ntolerable physical symptoms are not the reason most patients request physician-assisted suicide or euthanasia."⁸⁸ The Chief Justice concluded that research indicates that many people who request assisted suicide withdraw that request if their depression and pain are treated.⁸⁹ It is not clear, however, that all competent terminally-ill patients who desire

⁸⁵*Id.* at 2273-2274 (1997) (citing WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 13-22, 126-28 (New York State Task Force of Life and the Law, 1994)).

⁸⁶ 117 S. Ct. at 2273 (quoting Black, et al., *Physician-Assisted Suicide and Euthanasia in Washington State*, 275 JAMA 919, 924 (1996)).

⁸⁷ *Glucksberg*, 117 S. Ct. at 2273 (citing WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 175 (New York State Task Force of Life and the Law, 1994)).

⁸⁸ *Glucksberg*, 117 S. Ct. at 2274 (quoting *Physician-Assisted Suicide and Euthanasia in the Netherlands: A Report of Chairman Charles T. Canady to the Subcommittee on the Constitution of the House Committee on the Judiciary*, 104th Cong. 12-13 (1996)).

⁸⁹ *Glucksberg*, 117 S.Ct. At 2273 (citing H. HENDIN, *SEDUCED BY DEATH: DOCTORS, PATIENTS AND THE DUTCH CURE* 24-25 (1997)).

physician assistance in hastening the dying process are clinically mentally depressed. It may be true that a state law regulating physician-assisted suicide should properly require a determination and documentation in the medical record that a patient is not acting out of depression when requesting physician-assisted suicide; but the fact that some terminally-ill patients may be clinically depressed and not competent is not a sufficient reason to deny decision making capacity to nondepressed, competent, terminally-ill patients.

Finally, the Chief Justice again cites the New York State Task Force for the proposition: "physicians and medical professionals often fail to respond adequately to serious ill patient's needs."⁹⁰ It may be granted there is a need to improve the quality of pain management rendered by a health care provider. Nevertheless, it is important to understand that pain management is only one of the personal interests at stake in the claim of competent terminally-ill patients to physician assistance in hastening the dying process. These patients also have interests in dying with dignity, in avoiding unnecessary conditions of dependency and helplessness, and exercising their autonomy in the dying process.

To support his view that recognition of physician-assisted suicide will lead to involuntary euthanasia, the Chief Justice places heavy reliance on an account of the Netherlands experience with physician-assisted suicide reporting that revealed a large number of cases involving lethal morphine overdoses without the patients' explicit consent. According to this report, these abuses occurred despite regulations limiting prosecutorial tolerance of physician assistance in providing lethal medication to cases involving an explicit patient request.⁹¹ While the Dutch experience merits study, it is by no means clear that the Dutch experience would be reproduced in the United States. Abortion has been practiced widely in China with many reported abuses including abortion for sex selection; it is clear, however, that abortion practice in the United States has not been characterized by these same abuses.⁹²

⁹⁰*Id.* at 2293.

⁹¹*Washington v. Glucksberg*, 117 S. Ct. at 2274.

⁹²*See Chinese Aborting Female Fetuses*, CHGO TRIB. (Oct. 17, 1997) at A13, sec 1, col. 1.

In his opinion in *Vacco v. Quill*, the Chief Justice considered the Second Circuit's finding of a denial of Equal Protection in the application of New York's law banning physician-assisted suicide.⁹³ The Second Circuit found the practice of withdrawal or withholding of treatment leading to death to be equivalent to physician-assisted suicide.⁹⁴ Thus, the Second Circuit found a denial of Equal Protection; because those in the final stages of terminal illness who are on life-support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated, except for the lack of previous attachment of life-sustaining equipment, are not allowed to hasten death by self-administering prescribed drugs.⁹⁵ The Second Circuit found no rational basis for the state's differing treatment of mentally competent terminally-ill patients who want life-support removed in order to hasten the dying process and those who wish to be administered a lethal dose of medication in order to hasten the dying process.

The Chief Justice found the New York statute, by its terms, did not infringe on any fundamental right, nor did it involve suspect classifications.⁹⁶ Justice Rehnquist concluded that the distinction made in New York between assisting suicide and withdrawing life-sustaining treatment is a distinction widely endorsed and recognized by the legal tradition and the medical profession based on principles of causation and intent.

The issue of causation is first addressed by the Chief Justice: "[W]hen a patient refuses life-sustaining medical treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by the medication."⁹⁷ It would seem straightforward to recognize that when nutrition and hydration are withheld, a patient will die from starvation or dehydration unless another cause of death intervenes. Moreover, when medications are administered to facilitate death by starvation or dehydration, it would seem clear that those medications are administered as part of a process to

⁹³*Vacco v. Quill*, 117 S. Ct. 2293 (1997).

⁹⁴*Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996).

⁹⁵*Id.* at 728.

⁹⁶*Vacco*, 117 S. Ct. at 2297-2298.

⁹⁷*Id.* at 2298.

facilitate the death of the patient. However, the Chief Justice chooses to cite the opinion of the New Jersey Supreme Court in the *Matter of Conroy* for a more indirect explanation that "when the feeding tube is removed, death 'result[s] ... from [the patient's] underlying medical condition.'"⁹⁸ It is true the underlying medical condition is the cause of the patient's inability to obtain nutrition or hydration without mechanical assistance; nonetheless, it remains true that death will be directly caused by starvation and dehydration if nutrition and hydration are withheld or withdrawn.

According to the Chief Justice, the issue of intent is even more significant in distinguishing physician conduct in withholding or withdrawing treatment and physician-assisted suicide. The Chief Justice maintains the intent of the physician in withdrawing or withholding is to honor a patient's initial wish, and the physician intends only "to cease doing useless and futile or degrading things to a patient when [the patient] no longer stands to benefit from them."⁹⁹ Contrastingly, the physician who provides a patient lethal medication, directly intends to assist in causing the patient's death.¹⁰⁰

Justice Rehnquist does not seem to entertain the possibility that in providing a patient lethal medication, the physician may intend only to meet the patient's request for such medication without any intent or desire that the patient use or not use the medication to cause death. Nor does he consider the possibility that the physician may intend to, or know to a certainty, that his action will cause the patient's death when the physician withdraws treatment, including nutrition and hydration.

JUSTICE SOUTER'S ANALYSIS OF THE REASONABLENESS OF THE STATE'S INTEREST IN PROTECTING VULNERABLE PATIENTS BY PROHIBITING ASSISTED SUICIDE

Justice Souter's opinion provides an alternative analysis to that provided by the Chief Justice, while at the same time providing a much

⁹⁸*Id.* at 2299 (citing *Matter of Conroy*, 98 N.J. 321, 355, 586 A.2d 1209, 1226 (1985)).

⁹⁹*Id.* at 2298.

¹⁰⁰*Id.* at 2299.

narrower formulation of the issue before the Court. According to Justice Souter, "the question is whether a state statute making it a crime to aid another person to attempt suicide sets up one of the 'arbitrary impositions' or 'pointless restraints' at odds with the Due Process Clause of the Fourteenth Amendment."¹⁰¹ Justice Souter is willing to answer the narrower question of whether it would violate substantive due process to enforce a criminal statute prohibiting assisted suicide against a physician who acceded to a dying patient's request for a drug to be taken by the patient to commit suicide.¹⁰²

Justice Souter sets out to determine what the respondents must show to establish their claim that the Washington statute deprives them of a right falling within the scope of liberty under the Due Process clause of the Fourteenth Amendment. According to Justice Souter, the respondents have a very heavy burden to meet when claiming the state has "no substantively adequate justification for barring the assistance sought by the patient and sought to be offered by the physician" to hasten the patient's death.¹⁰³

Justice Souter provides a scholarly and detailed evaluation of the doctrine of substantive due process from the early Eighteenth Century onward. He finds himself in strong agreement with the dissent of Justice Harlan in *Poe v. Ullman* that when faced with a claim based on substantive due process, the task is not to identify an absolute right outside the text of the Constitution, but to engage in judicial scrutiny of the legislative resolution of "clashing principles, each quite possibly worthy in and of itself, but each to be weighed within the history of our values as a people."¹⁰⁴ Instead of viewing the task as one of finding some historically based right, much less identification of mere judicial preference for recognition of some claim of right, the Court must make an examination of a state's legislation or regulation to determine whether it is without justification.

According to Justice Souter, appropriate judicial review should not "substitute one reasonable resolution of the contending positions for

¹⁰¹Washington v. Glucksberg, 117 S. Ct. 2258, 2275 (1997) (Souter, J., concurring).

¹⁰²*Id.* at 2277.

¹⁰³*Id.* at 2277.

¹⁰⁴*Id.* at 2281 (citing *Poe v. Ullman*, 367 U.S. 497, 543 (1961) (Harlan, J., dissenting)).

another," but should be restricted to replacing "the balance already struck between the contenders only when it falls outside the realm of reasonable."¹⁰⁵ Thus, a liberty claim like that posed by the respondents, is a claim of right to be free from "arbitrary impositions and purposeless restraints."¹⁰⁶

Justice Souter identifies various elements of the Due Process analysis that establish the burdens which advocates for recognition of a constitutional right must meet. Justice Souter points out,

When identifying and assessing the competing interests of liberty and authority, for example, the breadth and expression that a litigant or a judge selects in stating the competing principles will have much to do with the outcome and may be dispositive. As in any process of rational augmentation, we recognize that when a generally accepted principle is challenged, the broader the attack, the less likely it is to succeed.¹⁰⁷

This approach leads Justice Souter to a narrower formulation of the question than that provided by the Chief Justice. Yet, Justice Souter recognizes such a narrow formulation may be untenable if it mistakenly presumes conditions or constraints which make it impossible to accommodate the valid concerns of the state regulation. Indeed, according to Justice Souter, it is likely these concerns will be clear in a broader formulation of the interests at stake. Justice Souter provides his formulation of the claims made by the parties in this case by refusing to term it as a general claim for anyone to assist in any suicide, under any circumstances, namely the right of physicians to provide competent, terminally-ill patients assistance in hastening the dying process. Rather, Justice Souter presents the claim as involving the right of a narrow class (*i.e.*, physicians] to help others in a narrow class (*i.e.*, competent terminally-ill patients) *under a set of limited circumstances*. However, Justice Souter also notes the claimants are met with the State's assertion

¹⁰⁵*Id.*

¹⁰⁶*Washington v. Glucksberg*, 117 S. Ct. 2258, 2282 (1997) (Souter, J., concurring).

¹⁰⁷*Id.* at 2284.

that recognizing such a narrow scope of rights jeopardizes individuals whom the state may concededly protect through its regulations.¹⁰⁸

Justice Souter recognizes that neither the patients' claim to physician assistance in obtaining counsel and medication to be administered to hasten death, nor the physicians' claim of a right to provide such aid, are historically based. Instead, Souter views the case as involving the claim of patients to access the services of a physician to give them the benefit of advice and medical help, which is said to enjoy a tradition so strong and so devoid of specifically countervailing state concern that denial of a physician's help in these circumstances is arbitrary when physicians are generally free to advise and aid those who exercise other rights to bodily autonomy.¹⁰⁹

Justice Souter identifies three bases for establishing the claim to a right of competent terminally-ill patients to physician assistance in hastening the dying process:

- (1) The states decriminalization of suicide reflects a social rejection of the tradition that abhorred and condemned suicide. Moreover, the state's rejection of the traditional criminal law prohibition of suicide raises the question as to the criminality of assisting suicide that previously would not have been considered.
- (2) The state's decriminalization of suicide suggests a recognition of rights of bodily autonomy which may be exercised in conduct that the state may still wish to discourage.
- (3) The claim being made for a competent terminally-ill patient to physician assistance in hastening the dying process is rooted in the traditional right to medical care and advice subject to the explicit conditions of informed responsible choice when death is imminent.

Justice Souter places significance on the fact that Washington decriminalized suicide, while continuing to prohibit assistance to one committing suicide.¹¹⁰ Although he rejects the argument that

¹⁰⁸*Id.* at 2286 (Souter, J., concurring).

¹⁰⁹*Id.*

¹¹⁰*Id.* at 2287.

decriminalization implies the recognition by the state of a liberty interest in suicide, Justice Souter does acknowledge decriminalization "opens the door to the assertion of a cognizable liberty interest in bodily integrity and associated medical care that would otherwise have been in apposite so long as suicide, as well as assisting a suicide, was a criminal offense."¹¹¹

Common law recognition of the right to be free from medical invasions into the body, as well as a right to refuse medication are readily acknowledged by Justice Souter. Unlike Justice Rehnquist, Justice Souter agrees with respondents that the Court's decisions in *Cruzan* and *Casey* have significance for determining the question of the right to physician-assisted suicide.¹¹² Both the right to require physicians to terminate artificial life support¹¹³ and the right to obtain medical intervention to cause abortion¹¹⁴ are based, according to Justice Souter, on constitutional recognition of the right of bodily integrity.¹¹⁵ This analysis leads Justice Souter to recognize that the claim to physician assistance in hastening the dying process falls within the accepted tradition of medical care.

There are strong analogies between physician assistance in hastening the dying process and physician assistance in obtaining an abortion that are recognized by Justice Souter:

Even though the State has a legitimate interest in discouraging abortion. The Court recognized a woman's right to a physician's counsel and care. Like the decision to commit suicide, the decision to abort potential life can be made irresponsibly and under the influence of others, and yet the Court has held in the abortion cases that physicians are fit assistants. Without physician assistance in abortion, the woman's right would have too often amounted to nothing more than a right to self-mutilation, and without a physician to assist in the suicide of the dying, the patient's right will often be confined to crude methods of causing death, most shocking and painful to the decedent's survivors [I]n the course of holding that the decision to perform an abortion called for a physician's

¹¹¹*Washington v. Glucksberg*, 117 S. Ct. 2258, 2284 (1997) (Souter, J., concurring).

¹¹²*Id.* at 2288; compare, *id.* at 2270 (majority opinion Justice Rehnquist).

¹¹³*Id.* at 2288 (citing *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 279 (1990)).

¹¹⁴*Id.* (citing *Planned Parenthood v. Casey*, 505 U.S. 833, 849 (1992)).

¹¹⁵*Washington v. Glucksberg*, 117 S. Ct. 2258, 2288 (1997) (Souter, J., concurring).

assistance, the Court recognized that the good physician is not just a mechanic of the human body whose services have no bearing on a person's moral choices, but one who does more than treat symptoms, one who ministers to the patient.¹¹⁶

Thus, Justice Souter suggests respondents make a valid argument for their asserted interest in a right to physician-assisted suicide. Moreover, he suggests there is a counter argument to the position that recognition of physician-assisted suicide right would compromise the integrity and ethics of the medical profession. According to Justice Souter, a physician who provides assistance in hastening the dying process may be viewed as basic to the physician-patient relationship,

This idea of the physician as serving the whole person is a source of the high value traditionally placed on the medical relationship. Its value is surely as apparent here as in the abortion cases, for just as the decision about abortion is not directed to correcting some pathology, so the decision in which a dying patient seeks help is not so limited.¹¹⁷

Unlike Justice O'Connor who views the principal concern of respondents to be pain management,¹¹⁸ and more like Justice Breyer who would formulate the respondents claim to be one to the right to die with dignity,¹¹⁹ Justice Souter sees the respondent s' claim to be a complex interest in avoiding pain, achieving death with dignity, and maintaining personal autonomy:

The patients here sought not only an end to pain (which they might have had although perhaps at the price of a stupor) but an end to their short remaining lives with a dignity that they believed would be denied them by powerful pain medication, as well as by their consciousness of dependency and helplessness as they approached

¹¹⁶*Id.* at 2288 [Citations omitted].

¹¹⁷*Id.* at 2289.

¹¹⁸*Washington v. Glucksberg*, 117 S. Ct. 2302, 2303 (1997) (O'Connor, J., concurring).

¹¹⁹*Id.* at 2311. (separate concurring opinions for *Washington v. Glucksberg* and *Quill v. Vacco*) (Breyer, J., concurring).

death. In that period when the end is imminent, they said, the decision to end life is the closest to decisions that are generally accepted as proper instances of exercising autonomy over one's own body, instances recognized under the Constitution and the State's own law, instances in which the help of physicians is accepted as falling within the traditional norm.¹²⁰

Justice Souter goes on to identify three situations where physicians are able to act that are similar to the situation in which the respondents are asking for physician assistance. Primarily, physicians may withhold or withdraw life-sustaining treatment and terminate artificial delivery of nutrition and hydration to patients who request their physician to do so, even though the physicians action will undoubtedly hasten death. Secondly, physicians may alleviate the anxiety and discomfort of patients whose life-sustaining treatment is withdrawn or whose nutrition and hydration is withheld by administering medication that will hasten death further. And finally, physicians may administer medication to terminal patients with the intent to alleviate pain, even when that medication will have the effect of hastening the patient's death.

Justice Souter is unequivocal in recognizing the strength of the claim of a competent terminal patient to physician assistance in hastening the dying process: "There can be no stronger claim to a physician's assistance than at the time when death is imminent, a moral judgment implied by the State's own recognition of the legitimacy of medical procedures necessarily hastening the moment of impending death."¹²¹

In stark contrast to Justice Rehnquist who finds no basis for a claim of a competent terminal patient to physician assistance in hastening the dying process,¹²² Justice Souter finds that the respondents have made a strong showing to establish their claim.¹²³ Nonetheless, it is the application of the second part of the due process analysis that bring Justice Souter conclusion that the respondents failed to establish a lack of sufficiency in the state's reasons for refusing to recognize the respondent's

¹²⁰Washington v. Glucksberg, 117 S. Ct. 2258, 2289 (1997) (Souter, J., concurring).

¹²¹*Id.* at 2290.

¹²²*Id.* at 2271.

¹²³*Id.* at 2290 (Souter, J., concurring).

claim to a right to physician assistance in hastening death. While Justice Souter admits it "cannot be gainsaid" that the respondents' claim falls, "within that class of 'certain interests' demanding careful scrutiny of the state's contrary claim," he concludes that the State's interests weighed against the formulation of the claim made by the respondents "are sufficiently serious to defeat the present claim that [the state's law] is arbitrary or purposeless."¹²⁴

Significantly Justice Souter expresses an important caveat to this analysis leaving open the possibility of future litigation establishing a patient's right to physician assistance in hastening the dying process under particular circumstances. Specifically, Justice Souter recognized the Court might find that "interest might in some circumstances, or at some time, be seen as 'fundamental' to be degree entitled to prevail."¹²⁵

For the present, Justice Souter identifies three state interests that compel him to find that Washington law prohibiting assisting suicide as applied to physicians treating competent terminally-ill patients is not an arbitrary or a purposeless restriction. The interests include:

- (1) protecting life,
- (2) discouraging suicide, and
- (3) protecting terminally-ill patients from mistakenly and involuntarily deciding to end their lives, and guarding against both voluntary and involuntary euthanasia.¹²⁶

Without analyzing the first two interests, Souter concludes the third interests is dispositive given the formulation of the respondent's claim that was presented to the Court through litigation arising outside of the context of a system of statutes or regulations setting out procedures and standards controlling the practice of physician-assisted suicide.

Justice Souter identifies various reasons for giving significant weight to the state's interest in protecting terminally-ill patients:

¹²⁴*Id.*

¹²⁵Washington v. Glucksberg, 117 S. Ct. 2258, 2290 (1997) (Souter, J., concurring).

¹²⁶*Id.*

- (1) difficulty in identifying a clear standard for imminent death;
- (2) possibility of mistaken decisions resulting from inadequate palliative care;
- (3) possibility of erroneous determination of terminal prognosis;
- (4) possibility of coercion and abuse stemming from the high cost of medical care;
- (5) temptations for physicians to administer voluntary and involuntary euthanasia because of failure to identify patient's preference, or out of mistaken compassion;
- (6) obscuring of the line between ill and dying;
- (7) blurring the boundary between those responsibly deciding and those unduly influenced.¹²⁷

According to Justice Souter, the significance of the State's interests stems from the showing that "respondent's claim is not as narrow as it sounds, simply because no recognition of the interest they assert could be limited to vindicating those interests and affecting no others."¹²⁸

The underlying premise of Justice Souter's conclusion that the state's interest outweighs the respondent's claim is simply that the need of the state to protect vulnerable patients can only be achieved through the present general prohibition of suicide, and no statute regulating physician suicide could be drafted to effectively protect vulnerable persons the state has a proper interest in protecting. The contextual setting of this case permits Justice Souter's conclusion. Without a statute or set of regulations establishing standards and procedures for the practice of physician-assisted suicide, every abuse is arguably conceivable.

Respondents made a general claim of a right to physician assistance in hastening the dying process at the request of terminally-ill patients. Respondent's provided a general challenge to laws prohibiting suicide as applied to the situation of the competent terminally-ill patients. Respondent's position in the cases before the court left the determination of when and how to provide assistance to patients wishing to hasten the dying process to the physicians providing the assistance. Of course the

¹²⁷*Id.* at 2290-93.

¹²⁸*Id.* at 2290.

Court itself could formulate standards for exercising the right to physician assistance in hastening the dying process as the Court has done in the abortion cases.¹²⁹ It is obvious that the Court was reluctant to take such an affirmative course of action in these cases with the result that assisted suicide would have involved implicit recognition of a system of physician self-regulation in providing assistance in hastening patients' death.

The way the cases before the Court were framed implicitly presumed a system of physician self-regulation in providing assistance to patients wishing to commit suicide. Without a regulatory law setting down standards or procedures for physician-assisted suicide (including standards for: diagnosis, independent confirmation of diagnosis, psychological evaluation of the patients, criteria for diagnosis a terminal condition), it is easy to understand why Justice Souter was convinced that the state's interest in protecting vulnerable patient's would be jeopardized by a ruling in favor of the respondents. To avoid risk to vulnerable person, if the Court were to recognize a right to physician-assisted suicide, the Court would be forced to independently impose limits and requirements for exercise of the rights claimed by respondents.¹³⁰

The respondents placed heavy reliance on physician self-regulation to generate the kind of standards and procedures that would otherwise be provided by a regulatory law. Conversely, the State argued dependance on the vigilance of physicians was insufficient. Justice Souter contrasted the self-limiting nature of the Court's discussions in the contraception cases¹³¹ and the medical basis of the standards set out in the abortion cases¹³² to what he described to be as an open-ended matter of assessing "the knowing and responsible mind" of a terminal patient.¹³³ Thus, Justice Souter concluded it was beyond the competence of the Court to set out the conditions and limitation on the exercise of a right of patients to physician-assisted suicide.

¹²⁹Roe v. Wade, 410 U.S. 113, 93 S. Ct. 705, 35 L.Ed. 2d 147 (1973).

¹³⁰Washington v. Glucksberg, 117 S. Ct. 2258, 2290 (1997) (Souter, J., concurring).

¹³¹*Id.* at 2291 (citing Poe v. Ullman, 367 U.S. 497 (1961); Planned Parenthood v. Casey, 505 U.S. 833 (1992)).

¹³²Glucksberg, 117 S. Ct. at 2291 (Souter, J., concurring) (citing Roe v. Wade, 410 U.S. 113 (1973)).

¹³³*Id.* at 2291.

Justice Souter also was convinced that in the long run, physicians would not necessarily be committed to assiduously maintaining the narrow line suggested by respondents' formulation. Several factors were identified by Justice Souter as supporting the slippery slope argument that recognition of a right to physician assistance in hastening the dying process would likely lead to euthanasia:

- (1) compassion might lead a physician to providing assistance to a patient, whether the patient was technically responsible or not;
- (2) financial incentives, especially in the managed care situation, might lead to inappropriate physician action;
- (3) possible shift by an attending physician from providing lethal drugs to administering such medication.¹³⁴

Two possible responses to Justice Souter's analysis are anticipated by him: judicial establishment of requirements for the exercise of a circumscribed right to physician-assisted suicide and legislative regulation of the practice of physician-assisted suicide. Could not the Court set out standards and procedures for regulating this process as it has done in such differing situations as abortion¹³⁵ and the questioning of criminal suspects?¹³⁶ Justice Souter clearly recognizes such previous efforts of the Courts, particularly in the abortion cases. Nonetheless, Justice Souter concludes that there is something unique about the determination of patient preferences by physicians with mixed motives. According to Justice Souter, "The case for the slippery slope is fairly made out here, not because recognizing one due process right would leave a court with no principled basis to avoid recognizing another, but because there is a plausible case that the right claimed would not be readily containable by reference to facts about the mind that are matters of difficult judgment, or by gatekeepers who are subject to temptation, noble or not."¹³⁷

¹³⁴*Id.*

¹³⁵*Washington v. Glucksberg*, 117 S. Ct. 2258, 2291; *see also* *Roe v. Wade*, 410 U.S. 113 (1973).

¹³⁶*Glucksberg*, 117 S. Ct. at 2291 (Souter, J., concurring); *see, e.g.,* *Miranda v. Arizona*, 384 U.S. 436 (1966).

¹³⁷*Glucksberg*, 117 S. Ct. at 2291.

Justice Souter acknowledges the suggestion of respondents that the State's interest in protecting vulnerable patients could be vindicated by carefully drafted regulations providing standards and procedures for physician-assisted suicide. The suggestion calls for state legislation authorizing physician-assisted suicide which would require two qualified physicians to confirm a patient's diagnosis, prognosis, and competence.¹³³ Further, the suggested legislation would mandate that the patient make repeated requests witnessed by at least two others over a specific time span; and would impose reporting requirements and criminal penalties for various acts of coercion.¹³⁹ Nevertheless, Justice Souter remained unconvinced that the Court was in any position to determine that such recommended standards and procedures would be sufficient to guarantee the state's interest in protecting vulnerable persons.

Unlike Justice Rehnquist whose opinion cites only negative reports about of the Netherlands's experience with physician-assisted suicide as evidence of the inevitable movement from physician-assisted suicide to euthanasia,¹⁴⁰ Justice Souter more cautiously cites conflicting reports about the claimed failure of the Dutch procedures to protect vulnerable and unconsenting patients.¹⁴¹ Justice Souter also cited reports that indicate there have not been substantial incidents of physician abuse or non-compliance with mandated guidelines in the Netherlands.¹⁴² Yet, the existence of a factual disagreement about the Dutch experience with

¹³³*Id.* (citing amicus curiae brief on behalf of members of the New York and Washington state legislatures in support of petitions (Nos. 95-1858, 96-1110)).

¹³⁹*Id.* (citing amicus curiae brief on behalf of members of the New York and Washington state legislatures in support of petitioners (Nos. 95-1858, 96-1110)).

¹⁴⁰*Washington v. Glucksberg*, 117 S. Ct. 2258, 2274 (citing *Physician-Assisted Suicide and Euthanasia in the Netherlands: A Report of Chairman Charles T. Canady to the Subcommittee on the Constitution of the House Committee on the Judiciary*, 104th Cong. 12-13 (1996)).

¹⁴¹*Id.* at 2292 (citing J. Keown, *Euthanasia in the Netherlands: Sliding Down the Slippery Slope*, in *EUTHANASIA EXAMINED* 261, 289 (1995); C. GOMEZ, *REGULATING DEATH* 102-113 (1991)).

¹⁴²*Glucksberg*, 117 S. Ct. at 2292 (citing R. EPSTEIN, *MORAL PERIL* 322 (1997) (Dutch physicians are not euthanasia enthusiasts and they are slow to practice it in individual cases). R. POSER, *AGING AND OLD AGE* 242, n.23 (1995) (noting fear of "doctor's rushing patients to death" in the Netherlands "has not been substantiated and does not appear realistic")); Van der Weh, et al., *Euthanasia and Assisted Suicide 2, Do Dutch Family Doctors Act Prudently?* 2 *FAM. PRACT.* 135 (1992) (finding no serious abuse in Dutch experience).

physician-assisted suicide weighs heavily for Justice Souter in deciding the significance to be given to the state's claim of the need for its present law prohibiting physician-assisted suicide. In fact, for Justice Souter, the conflicting reports are "dispositive of the due process claim at this time."¹⁴³

It needs to be emphasized the essential determining influence for accepting the state's claim of an inability to protect vulnerable patients without maintaining the law prohibiting assisted suicide, without exception, turns on the conflicting arguments about the inability of the state to effect its interest in protecting vulnerable persons with regulatory, rather than prohibiting legislation. According to Justice Souter:

The capacity of the State to protect the others if respondents were to prevail is, however, subject to some genuine question, underscored by the responsible disagreement over the basic facts of the Dutch experience. This factual controversy is not open to a judicial resolution with any substantial degree of assurance at this time At this point, however, the factual issue at the heart of this case does not appear to be one of those [settled in a court]. The principal inquiry at the moment is the Dutch experience and I question whether an independent front-line investigation into the facts of a foreign country's legal administration can be soundly undertaken through American courtroom litigation. While an extensive literature on any subject can raise the hopes for judicial understanding, the literature on this subject is only nascent. Since there is little experience directly bearing on the issue, the most that can be said is that whatever way the Court might rule today, events could overtake its assumption, as experimentation in some jurisdictions confirmed or discredited the concerns about progression from assisted suicide to euthanasia.¹⁴⁴

Justice Souter does not suggest the Court should refuse to recognize a right to physician-assisted suicide on some absolutist narrow reading of the Constitution, because such an approach would require the Court to defer to the legislature on any question regarding a right not specifically set

¹⁴³*Glucksberg*, 117 S. Ct. at 2292 (Souter, J., concurring).

¹⁴⁴*Id.* at 2292, 2293.

out in the text of the Constitution. Instead, Justice Souter suggests that in this case, only through experimentation facilitated by state legislation can the case be made for a narrowly circumscribed procedure which allows competent terminally-ill patients to seek physician assistance in hastening the dying process while preventing the exposure of other vulnerable patients to physician abuse in coerced suicide or euthanasia.¹⁴⁵ Justice Souter does point out that state legislatures have the ability, unlike the courts, to resolve the factual controversy underlying the conflict between the respondent's claim and the state's interest. Citing the experience of the State of Oregon and its legislative initiative providing for physician-assisted suicide as evidence of the likelihood of desirable legislative experimentation in this area: "Not only do [legislatures] have more flexible mechanisms for factfinding than the Judiciary, but their mechanisms include the power to experiment, moving forward and pulling back as facts emerge within their own jurisdictions."¹⁴⁶

Of course the question remains whether state legislatures will be bold enough to adopt legislation providing procedures and standards regulating physician-assisted suicide. Even the Oregon experience reveals the timidity of state legislatures in addressing this matter. After the Oregon voters passed an initiative providing for physician-assisted suicide, the Oregon legislature required the electorate to revote on the matter.¹⁴⁷ Justice Souter, however, warns that legislative inaction may compel the Court to address patients' claims of a right to physician-assisted suicide, and then, for the Court by itself to set out the parameters for the exercise of such a right. Justice Souter writes: "I do not decide here what the significance might be of legislative foot-dragging in ascertaining the facts going to the State's argument that the right in question could not be confined as claimed. Sometimes a court may be bound to act regardless of the

¹⁴⁵Washington v. Glucksberg, 117 S. Ct. 2258 (1997) (Souter, J., concurring).

¹⁴⁶*Id.* at 2292 (Souter, J., concurring) (citing OR. REV. STAT. §§ 127.800-897 (1996)).

¹⁴⁷*See, e.g.,* T. Eagan, *Assisted Suicide Comes Full Circle in Oregon*, N.Y. TIMES, Oct. 26, 1997, at A1, col. 2 and A19, col. 1. The Oregon initiative, passed three years ago (1994) by 51 percent to 49 percent, allows doctors to prescribe a lethal dose of medications to terminally-ill patients who are of sound mind and have made a written request to die. Even as the law was snagged in court, the Oregon state legislature worked to stall its implementation, sending the act back to the people for repeal at A1.

institutional preferability of the political branches as formed for addressing constitution claims."¹⁴⁸

While Justice Souter clearly prefers state legislation to address and resolve the matter of effective regulation of physician-assisted suicide, he leaves the door open to future consideration by the Court of the question whether under certain circumstances a competent terminal patient has a right to physician assistance in hastening the dying process. Justice Souter concludes: "The Court should accordingly stay its hand to allow reasonable legislative consideration. *While I do not decide for all time that respondent's claim should not be recognized*, I acknowledge the legislative institutional competence as the better one to deal with that claim at this time."¹⁴⁹

JUSTICE STEVENS SUGGESTS A CONSTITUTIONAL RIGHT TO HASTEN DEATH UNDER PARTICULARIZED CIRCUMSTANCES

Justice Stevens agrees with the Court's opinion that there is not a categorical constitutional "right to commit suicide which itself includes a right to assistance in doing so."¹⁵⁰ Nonetheless, Justice Stevens would have the Court recognize there are situations in which an interest in hastening death is legitimate.¹⁵¹ Justice Stevens goes on to suggest a constitutional right to hasten death under particularized circumstances; by writing: "Indeed, not only is that interest sometimes legitimate, I am also convinced that there are times when it is entitled to constitutional protection."¹⁵²

Justice Stevens first attempts to show that the states have not maintained an absolute interest in preserving life by their practice of capital punishment. Citing three 1976 opinions of the United States Supreme Court on the question of constitutionality of the practice of capital

¹⁴⁸*Glucksberg*, 117 S. Ct. at 2293 (Souter, J., concurring).

¹⁴⁹*Id.* [Emphasis added].

¹⁵⁰*Washington v. Glucksberg*, 117 S. Ct. 2302, 2305 (1997) (separate concurring opinions for both *Washington v. Glucksberg* and *Vacco v. Quill*) (Stevens, J., concurring).

¹⁵¹*Id.*

¹⁵²*Id.*

punishment,¹⁵³ Justice Stevens points out, "[i]n those cases we concluded that a State does have the power to place a lesser value on some lives than on others; there is no absolute requirement that a State treat all human life as having an equal right to preservation."¹⁵⁴

Justice Stevens finds a second aspect of the capital punishment cases to be instructive in suggesting a broad finding that there is no categorical right to assist suicide does not preclude a narrower finding of exceptions to that rule. Justice Stevens writes: "[J]ust as our conclusion that capital punishment is not always unconstitutional did not preclude later decisions holding that it is sometimes impermissibly cruel, so is it equally clear that a decision upholding a general statutory prohibition of assisted suicide does not mean that every possible application of the statute would be valid."¹⁵⁵

Turning his attention to the Court's decision in *Cruzan v. Director, Missouri Department of Health*, Justice Stevens does not regard that decision as recognizing an absolute right of a patient to refuse treatment. In support of this assertion, Stevens cites legislation imposing punishment on persons refusing to be vaccinated¹⁵⁶ and cites with approval, Justice Scalia's observation in *Cruzan* that the state would ordinarily have the right to interfere with an attempt to commit suicide by acting to stop the blood flow from a person with a self-inflicted wound.¹⁵⁷

On the other hand, Justice Stevens would not give *Cruzan* the narrow reading given it by Justice Rehnquist.¹⁵⁸ Instead, Justice Stevens views

¹⁵³*Id.* at 2304 nn.1-3 (citing *Gregg v. Georgia*, 428 U.S. 156, (1976); *Proffitt v. Florida*, 428 U.S. 242 (1976); *Jurek v. Texas*, 428 U.S. 262 (1976)).

¹⁵⁴*Id.* at 2304 (separate concurring opinions for both *Washington v. Glucksberg* and *Vacco v. Quill*) (Stevens, J., concurring).

¹⁵⁵*Washington v. Glucksberg*, 117 S. Ct. 2258, 2305 (1997) (Souter, J., concurring).

¹⁵⁶*Id.* at 2306 (citing *Cruzan v. Director, Mo. Dept. of Health*, 497 U.S. 261, 312 n.12 (1990) (Brennan, J., dissenting); *Jacobson v. Massachusetts*, 197 U.S. 11, 26-27 (1905)).

¹⁵⁷*Glucksberg*, 117 S. Ct. at 2306 (1997) (separate concurring opinions for both *Washington v. Glucksberg* and *Vacco v. Quill*) (Stevens, J., concurring) (citing *Cruzan*, 497 U.S. at 298 (Scalia, J., concurring)).

¹⁵⁸*Washington v. Glucksberg*, 117 S. Ct. 2258, 2270 (1997) ("[t]he decision to commit suicide with the assistance of another may be just as personal and profound as the decision to refuse unwanted medical treatment, but it has never enjoyed similar legal protection In *Cruzan* itself, we recognized that most States outlawed assisted suicide — and even more do today — and we certainly gave no intimation that the right to refuse unwanted medical treatment could be somehow transmuted into a right to assistance in committing suicide.").

Cruzan as supporting a narrow claim of a patient to assistance in hastening the dying process.¹⁵⁹ Justice Stevens points out that *Cruzan* did not involve a patient with an illness that would respond to the normal course of medical treatment, and he emphasizes the significance of the "irreversible nature of her illness" and "the progressive character of her suffering."¹⁶⁰

For Justice Stevens, the *Cruzan* opinion was not simply a case of judicial vindication of a patient's right to refuse medical treatment, but further, *Cruzan* recognized a patient's broader "interest in refusing medical care [that] was incidental to her more basic interest in controlling the manner and timing of her death."¹⁶¹ Justice Stevens is quite specific in his recognition that the Court, "in essence, authorized affirmative conduct that would hasten her death."¹⁶²

Justice Stevens suggests that the *Cruzan* opinion has important implications for considering the claim that competent terminal patients have a right to physician assistance in hastening the dying process under certain circumstances. In fact, Justice Stevens, suggests the original patient plaintiffs in the physician-assisted suicide cases might have a stronger claim than Nancy Cruzan, because they were terminally-ill and suffering severe and constant pain.¹⁶³ Justice Stevens suggests several important implications of the *Cruzan* opinion for the present cases:

- (1) *Cruzan* did not involve simply the exercise of a common law right to refuse treatment; but a "freedom [that] embraces, not merely a person's right to refuse a particular kind of unwanted treatment, but also her interest in dignity, and in determining the character of the memories that will survive long after her death"; it involved "the even more fundamental right to make this 'deeply personal decision.'"¹⁶⁴

¹⁵⁹Washington v. Glucksberg, 117 S. Ct. 2302, 2306 (1997) (separate concurring opinions for both Washington v. Glucksberg and Vacco v. Quill)(Stevens, J., concurring).

¹⁶⁰*Id.*

¹⁶¹*Id.*

¹⁶²*Id.*

¹⁶³*Id.* at 2306-07.

¹⁶⁴Washington v. Glucksberg, 117 S. Ct. 2302, 2306 (1997) (separate concurring opinions for both Washington v. Glucksberg and Vacco v. Quill) (Stevens, J., concurring).

- (2) *Cruzan* recognized a "liberty interest" in refusing unwanted medical treatment that is protected by the Due Process clause that outweighed any relevant state interest.¹⁶⁵
- (3) The sphere of liberty protecting the right to have treatment withheld or withdrawn includes the protection of matters "central to personal dignity and autonomy." According to Justice Stevens, "[t]he *Cruzan* case demonstrated that some state intrusions on the right to decide how death will be encountered are also intolerable."¹⁶⁶

While conceding that the *Cruzan* opinion does not decide the issues presented to the Court in cases involving physician-assisted suicide, Justice Stevens is equally sure the *Cruzan* opinion did give recognition to an autonomy interest in "making decisions about how to confront an imminent death."¹⁶⁷

Justice Stevens offers his reading of the significance of the *Cruzan* case for resolving the narrow question of the right of competent terminally-ill patients to physician assistance in hastening the dying process under specific circumstances:

Although there is no absolute right to physician-assisted suicide, *Cruzan* makes it clear that *some individuals who no longer have the option of deciding whether to live or to die because they are already on the threshold of death have a constitutionally protected interest that may outweigh the State's interest in preserving life at all costs.* The liberty interest at stake in a case like this differs from, and is stronger than, both the common-law right to refuse medical treatment and the unbridled interest in deciding whether to live or die. It is an interest in deciding how, rather than whether, a critical threshold shall be crossed.¹⁶⁸

Using the same analytical approach as set out by Justice Souter,¹⁶⁹ yet establishing a much stronger claim by patients to physician-assisted suicide

¹⁶⁵*Id.*

¹⁶⁶*Id.* at 2307.

¹⁶⁷*Id.*

¹⁶⁸*Id.* [Emphasis added].

¹⁶⁹*Washington v. Glucksberg*, 117 S. Ct. 2258, 2290-93 (1997) (Souter, J., concurring).

than that developed by Justice Souter,¹⁷⁰ various state interests are set out and evaluated by Justice Stevens.¹⁷¹ These include the state's interest in preserving life, in preventing suicide, and in maintaining the integrity of the medical profession.

Justice Stevens maintains that the state interest in preserving life is not the same in all cases. Specifically, Justice Stevens recognizes that the state's interest may be outweighed by the interest of a person in hastening death in circumstances "because of pain, incapacity, or sedation [she] finds her life intolerable."¹⁷²

Justice Stevens does not anticipate physician-assisted suicide will be chosen by all terminally-ill and pain suffering patients, and he willingly concedes many terminally-ill patients may find life meaningful despite pain or dependence. According to Justice Stevens, some individuals find value in suffering; some wish to live to witness particular events; and others have religious scruples against hastening the dying process.¹⁷³ However, Justice Stevens also recognizes that some terminal patients will not wish to continue treatment, and some terminal patients will wish to hasten dying.¹⁷⁴ According to Justice Stevens: "[t]here are those who will want to continue aggressive treatment; those who would prefer terminal sedation; and those who will seek withdrawal from life-support systems and death by gradual starvation and dehydration."¹⁷⁵ Rejecting Justice Rehnquist's suggestion that recognition of physician-assisted suicide devalues the lives of the terminally-ill,¹⁷⁶ Justice Stevens instead asserts "it gives proper recognition to the individual's interest in choosing a final chapter that accords with her life story, rather than one that demeans her values and poisons memories of her."¹⁷⁷

¹⁷⁰*Id.* at 2292.

¹⁷¹*Washington v. Glucksberg*, 117 S. Ct. 2302, 2307-09 (1997) (separate concurring opinions for both *Washington v. Glucksberg* and *Vacco v. Quill*) (Stevens, J., concurring).

¹⁷²*Id.* at 2308.

¹⁷³*Id.*

¹⁷⁴*Id.*

¹⁷⁵*Id.*

¹⁷⁶*Washington v. Glucksberg*, 117 S. Ct. 2258, 2273 (1997).

¹⁷⁷*Washington v. Glucksberg*, 117 S. Ct. 2302, 2308 (1997) (separate concurring opinions for both *Washington v. Glucksberg* and *Vacco v. Quill*) (Stevens, J., concurring).

While conceding a general state interest in preventing suicide, Justice Stevens maintains that in the context of the terminally-ill suffering patient, the state's interest in preventing suicide is less significant.¹⁷³ Justice Stevens suggests measures can be taken to prevent coercion, to diagnose depression, and to treat depression and pain. Moreover, according to Justice Stevens, an individual who is not suffering from depression and who makes a rational, voluntary decision to seek assistance in dying is not victimized. If these measures are taken, Justice Stevens maintains the state interest in preventing physician-assisted suicide significantly lessens. Accordingly, he writes: "[T]he State's legitimate interest in preventing abuse does not apply to an individual who is not victimized by abuse, who is not suffering from depression, and who makes a rational and voluntary decision to seek assistance in dying."¹⁷⁹

Recognizing the state's interest in preserving the traditional integrity of the medical profession, Justice Stevens warns against too narrow a view of the physician as "healer." On the contrary, Justice Stevens notes "for some patients, it would be a physician's refusal to dispense medication to ease their suffering and make their death tolerable and dignified that would be inconsistent with the healing role."¹⁸⁰ Moreover, since physicians are already involved in decisions to withhold or withdraw treatment that results in hastening death, there may already be a significant change in the understanding of the role of the physician.¹⁸¹

Justice Stevens concedes that the distinction between permitting death to ensue from an underlying fatal disease and causing it to occur by the administration of medication or other means provides a constitutionally significant basis for distinguishing the refusal of treatment and a request for physician-assisted suicide.¹⁸² Significantly, Justice Stevens does not directly recognize the withholding or withdrawal of nutrition and hydration may be the cause death, although he acknowledges earlier in his opinion that some patients may seek "death by gradual starvation and

¹⁷³*Id.*

¹⁷⁹*Id.*

¹⁸⁰*Id.*

¹⁸¹*Id.* at 2309.

¹⁸²*Washington v. Glucksberg*, 117 S. Ct. 2302, 2309-10 (1997) (separate concurring opinions for both *Washington v. Glucksberg* and *Vacco v. Quill*) (Stevens, J., concurring).

dehydration.”¹⁸³ Justice Stevens, instead, suggests that the distinction may be illusory; because, “I am not persuaded that in all cases there will in fact be a significant difference between the intent of the physicians, the patients or the families in the two situations.”¹⁸⁴

Justice Rehnquist maintains a physician’s intent is necessarily different in withholding or withdrawing treatment (the physician’s intent is to comply with the patient’s stated desire) and in providing the patient a lethal dose of medication (the physician’s intent is to cause the patient’s death).¹⁸⁵ Justice Stevens properly suggests the intent of a person may be the same in the withholding/withdrawal situation and the physician-assisted suicide situation because patients in both situations may intend to hasten death and a physician in either case may simply intend to comply with the patient’s stated desire, or alternatively may wish to assist in hastening death.¹⁸⁶

Much is made in the opinions of Justice O’Connor¹⁸⁷ and Justice Breyer¹⁸⁸ about the need to provide palliative care in the form of medication for pain relief even to the extent that such medication will hasten or cause death. Justice Stevens, however, suggests that recognition of a right to pain relief through medication that may hasten or cause death ultimately blurs the distinction between physician-assisted suicide, and permitting death to take place.¹⁸⁹ Justice Stevens writes:

The illusory character of any differences in intent or causation is confirmed by the fact that the American Medical Association unequivocally endorses the practice of terminal sedation -- the administration of sufficient dosages of pain-killing medication to terminally-ill patients to protect them from excruciating pain even

¹⁸³*Id.* at 2308.

¹⁸⁴*Id.* at 2310.

¹⁸⁵*Vacco v. Quill*, 117 S. Ct. 2293, 2298-99 (1997).

¹⁸⁶*Washington v. Glucksberg*, 117 S. Ct. 2302, 2310 (1997) (separate concurring opinions for both *Washington v. Glucksberg* and *Vacco v. Quill*) (Stevens, J., concurring).

¹⁸⁷*Id.* at 2303 (separate concurring opinions for both *Washington v. Glucksberg* and *Vacco v. Quill*) (O’Connor, J., concurring).

¹⁸⁸*Id.* at 2311-12 (separate concurring opinions for both *Washington v. Glucksberg* and *Vacco v. Quill*) (Breyer, J., concurring).

¹⁸⁹*Id.* at 2310 (separate concurring opinions for both *Washington v. Glucksberg* and *Vacco v. Quill*) (Stevens, J., concurring).

when it is clear that the time of death will be advanced. *The purpose of terminal sedation is to ease the suffering of the patient and comply with her wishes, and the actual cause of death is the administration of heavy doses of lethal sedatives. This same intent and causation may exist when a doctor complies with a patient's request for lethal medication to hasten her death.*¹⁵⁰

Justice Stevens comes to the conclusion that although the differences between intent and causation in the situation of treatment termination and the situation of physician-assisted suicide may support Justice Rehnquist's analysis of a facial challenge to a state's law prohibiting assisted suicide,¹⁹¹ the distinctions may be inapplicable when considering the claim of a terminally-ill patient to physician assistance in hastening the dying process.¹⁹²

Justice Stevens finds the state's interest in prohibiting assisted suicide will not always outweigh the underrated liberty interest of a particular patient to physician assistance in hastening the dying process.¹⁹³ While rejecting the categorical claim that the state's interests are invalid as to the entire class of competent patients, Justice Stevens concludes that "*I do not, however, foreclose the possibility that an individual plaintiff seeking to hasten her death, or a doctor whose assistance was sought, could prevail in a more particularized challenge.*"¹⁹⁴

THE FUTURE OF THE QUEST FOR RECOGNITION OF A RIGHT TO PHYSICIAN ASSISTANCE IN HASTENING THE DYING PROCESS

The various opinions of the Justices in these cases anticipate that the debate about physician-assisted suicide will continue in the legislatures and the courts. Chief Justice Rehnquist, speaking for the Court, made it clear

¹⁹⁰*Id.*[Emphasis added.]

¹⁹¹*Washington v. Glucksberg*, 117 S. Ct. 2302 (1997).

¹⁹²*Id.*

¹⁹³*Id.*

¹⁹⁴*Id.* at 2309 (separate concurring opinions for both *Washington v. Glucksberg* and *Vacco v. Quill*) (Stevens, J., concurring). [Emphasis added.]

that such continued debate leading to the establishment of circumscribed procedures and standards for physician-assisted suicide is in no way precluded by the Court's opinions. The Chief Justice concludes his opinion with the observation that, "Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society."¹⁹⁵

Justice Souter is firm in his conviction that the state legislatures must address the issue of whether the claim of patients under circumscribed conditions for physician assistance in hastening the dying process can be accommodated without jeopardizing the state's interest in protecting vulnerable persons. He goes even further to raise the possibility that legislative inaction may necessitate the Court's reconsidering the question of physician-assisted suicide. As Justice Souter warns, "I do not decide here what the significance might be of legislative foot-dragging in ascertaining the facts going to the State's argument that the right in question could not be confined as claimed. Sometimes a court may be bound to act regardless of the institutional preferability of the political branches as forums for addressing constitutional claims."¹⁹⁶ It is clear that Justice Souter views as valid the interest of properly qualified patients to physician assistance in hastening the dying process. Further, although he prefers that the legislatures develop a statutory scheme to accommodate this interest, Justice Souter does not rule out judicial recognition of a patient's right to assistance in hastening death, in the event of legislative inaction. Justice Souter concludes his opinion with the observation, "The Court should accordingly stay its hand to allow reasonable legislative consideration. While I do not decide for all time that respondents' claim should not be recognized, I acknowledge the legislative institutional competence as the better one to deal with that claim at this time."¹⁹⁷

Justice O'Connor not only recognizes the current activity of state legislatures addressing the issue of physician-assisted suicide, but she also endorses striking a balance between the interests of patients suffering from

¹⁹⁵Washington v. Glucksberg, 117 S. Ct. 2258, 2275 (1997).

¹⁹⁶*Id.* at 2293 (Souter, J., concurring).

¹⁹⁷*Id.* (Souter, J. concurring).

terminal illness and the state's interest in protecting vulnerable populations. Justice O'Connor writes, "Every one of us at some time may be affected by our own or a family member's terminal illness. There is no reason to think the democratic process will not strike the proper balance between the interests of terminally-ill, mentally competent individuals who would seek to end their suffering and this State's interests in protecting those who might seek to end life mistakenly or under pressure."¹⁹³ In concluding her observation, Justice O'Connor notes, "States are presently undertaking extensive and serious evaluation of physician-assisted suicide ... [i]n such circumstances, 'the ... challenging task of crafting appropriate procedures for safeguarding ... liberty interests is entrusted to the 'laboratory' of the States ... in the first instance."¹⁹⁹

The Court's opinions make it clear there is no constitutional prohibition or obstacle to state enactment of laws providing for physician-assisted suicide. The Court's recent ruling in *Lee v. Harclerod* gave tacit recognition to the appropriateness of state legislation establishing the right to physician-assisted suicide²⁰⁰ by turning down an appeal from the Ninth Circuit. The Ninth Circuit had ordered dismissal of a lawsuit brought by physicians and patients who sought an injunction to prevent the Oregon Death With Dignity Act from going into effect.²⁰¹

While it is not within the scope of this article to set out all of the specifics of a proper statute establishing and regulating physician-assisting suicide, certain fundamental elements of such a legislation can be identified. In developing a law providing for patients to receive physician assistance in hastening the dying process, requirements need to be established to ensure that the patient's request is informed and voluntary. Primary care physicians should be required to discuss all feasible alternatives with the

¹⁹³*Washington v. Glucksberg*, 117 S. Ct. 2302, 2303 (1997) (separate concurring opinions for both *Washington v. Glucksberg* and *Vacco v. Quill*) (O'Connor, J., concurring).

¹⁹⁹*Id.* (citing *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 292 (1990) (O'Connor, J., concurring)).

²⁰⁰*Lee v. Harclerod*, No. 96-1824, 1997 WL 274930 (U.S. Oct. 14, 1997) (memorandum opinion denying certiorari).

²⁰¹*Lee v. Oregon*, 107 F.3d 1382 (9th Cir. 1997), *rev'g* *Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995), *Lee v. Oregon*, 891 F. Supp. 1439 (D. Or. 1995); *see* OR. REV. STAT. § 127.800 - 897 (1996) (the Oregon Death With Dignity Act, Ballot Measure 16).

dying patient including the full extent of available palliative care and pain relief, and the availability of hospital care.

The patient should be required to make repeated requests for physician assistance. The patient should be required to make at least one written request and at least one subsequent oral request. To insure careful consideration of the matter by the patient, an oral request should be required to be made at least ten days after the written request. The patient should be required to be told of the ability to revoke the request at any time and in any manner.

A law providing for competent terminally-ill patients to receive physician assistance in hastening death needs to establish eligibility criteria for such assistance. It is basic to such a law that it requires the establishment of a terminal and irreversible disease or condition that is reasonably expected, according to established medical criteria, to produce death within a given period, perhaps within a six month period, in order for a patient to qualify for physician-assisted suicide. Such a law should require at least two qualified physicians to confirm the patient's diagnosis and prognosis. The medical record should document the physicians' determinations, as well as the fact that all written and oral requests by the patient are voluntary, by providing a record of all counseling sessions and the offer of the attending physician to rescind the patient's request.

A statute providing for physician-assisted suicide should require a determination for eligibility through an evaluation of the patient by a mental health specialist to determine competence and absence of clinical depression. This determination should be confirmed by a second mental health specialist.

A procedure should be established to authenticate a patient's request for physician assistance in hastening the dying process. This might include a requirement of at least two repeated requests witnessed by two persons, not related to the patient and not members of the health care team treating the patient.

A statute regulating physician-assisted suicide should prohibit making insurance benefits or health care services contingent on the patient's request for physician-assisted suicide. The statute should include reporting requirements and criminal penalties for acts of coercion or duress, and for failure to comply with the requirements of the statute.

In developing a statute governing physician-assisted suicide, it would also be desirable for legislatures to consider giving attention to the problem of palliative care and pain control by requiring that these alternatives be provided to a patient for a stated period before the option of physician-assisted suicide could be considered.

Of course, the possibility of future litigation remains, as indicated by a number of the Justices who suggested that in a case involving particularized qualifying conditions, the Court might grant recognition of a claim to a right to physician assistance in hastening the dying process. Justice Stevens specifically endorsed the possibility of vindication of a patient's claim to physician-assisted suicide under certain circumstances. Justice Rehnquist agreed with Justice Stevens' position in footnote 24 of the Court's opinion where he wrote: "Our opinion does not absolutely foreclose such a claim."²⁰²

Justice Souter perhaps would find a broader constitutional claim by patients to physician-assisted suicide if the state's interest in protecting vulnerable patients could be achieved while accommodating the claim of patients to physician assistance in hastening the dying process. Justice Souter clearly states: "I do not decide for all time that respondents' claim should not be recognized."²⁰³

Both Justice O'Connor and Justice Breyer identify the kind of special circumstances that might allow a competent terminal patient to prevail in a claim to a right to physician assistance in hastening the dying process. Justice O'Connor maintains that since the Court only considered facial challenges to the Washington and New York statutes, there was no need to reach the question whether "a mentally competent person who is experiencing great suffering has a constitutionally cognizable interest in controlling the circumstances of his or her imminent death."²⁰⁴ On the other hand, Justice Breyer maintains a state's law would be unconstitutional if it could be shown "to prevent the provision of palliative care, including the administration of drugs as needed to avoid pain at the

²⁰²Washington v. Glucksberg, 117 S. Ct. 2258, 2275 n.24 (1997).

²⁰³*Id.* at 2293 (Souter, J., concurring).

²⁰⁴Washington v. Glucksberg, 117 S. Ct. 2302, 2303 (1997) (separate concurring opinions for both Washington v. Glucksberg and Vacco v. Quill) (O'Connor, J., concurring).

end of life."²⁰⁵ Establishment of the inadequacy of palliative care to relieve pain should be sufficient to meet the requirement of the special circumstances for a patient to prevail in a claim to a right to physician-assisted suicide. According to Justice Breyer: "[I]n my view, the avoidance of severe physical pain (connected with death) would have to compromise an essential part of any successful claim."²⁰⁶

Advocates for patients seeking physician assistance in the dying process may prevail if they are able to develop a body of evidence showing the limits of palliative care in relieving suffering fall short of relieving significant pain of particular terminal patients. Such advocates will need to show that certain competent terminally-ill patients do, in fact, suffer unrelieveable pain if these advocates wish to establish a constitutional right to physician-assisted suicide under the rubric of the various opinions issued in *Washington v. Glucksberg*.²⁰⁷

It is certainly beyond the scope of this article to develop an empirical case for the assertion that some patients suffer unrelievable pain; nevertheless, it is clear there are reports in the medical literature that such is the case. In response to the assertion that most physical pain can be relieved with the appropriate use of analgesic agents, a physician reported in the *NEW ENGLAND JOURNAL OF MEDICINE*: "This is certainly far from my own experience, and I have observed that dysphoria and other terrible sensations may persist despite vigorous and innovative attempts to control them. In addition, many dying patients must also endure the nausea, dysphoria, and helplessness caused by their treatments."²⁰⁸

²⁰⁵*Id.* at 2312 (separate concurring opinions for both *Washington v. Glucksberg* and *Vacco v. Quill*) (Breyer, J., concurring).

²⁰⁶*Id.* at 2311.

²⁰⁷*Washington v. Glucksberg*, 117 S. Ct. 2258, 2275 (1997) ("[w]e need not weigh exactly the relative strengths of these various interests ... [o]ur holding today permits this debate to continue ..."); *Washington v. Glucksberg*, 117 S. Ct. 2302, 2311 (1997) (separate concurring opinions for both *Washington v. Glucksberg* and *Vacco v. Quill*) (Breyer, J., concurring) ("I would not reject respondents' claim without considering ... the avoidance of unnecessary and severe physical suffering ..."); *Id.* at 2310 (Stevens, J., concurring) (there is a liberty interest "that may justify the only possible means of ... alleviating [a dying patient's] intolerable suffering.").

²⁰⁸Richard Finley, *Euthanasia Debate [Letter]*, 323 *NEW ENG. J. OF MED.* 1771 (1990).

Despite the possibility of future litigation and vindication of competent terminal patients under some circumstances to a constitutional right to physician assistance in hastening the dying process, one can expect that the question of whether, and under what circumstances competent patients have a right to physician-assisted suicide is now a matter that will be debated before state legislatures²⁰⁹ and will be a likely subject of future voter initiatives.

²⁰⁹According to the Hemlock Society, fifteen states (including Alaska, Arizona, California, Colorado, Connecticut, Hawaii, Illinois, Maine, Maryland, Massachusetts, Nebraska, New Hampshire, New Mexico, Oregon, and Vermont) have considered legislation which would have permitted terminally-ill patients the right to die. See Hemlock Society, *Legislative Matters: Update on Legislative Action by State Law* (as of August, 1997) <<http://www2.privatei.com/hemlock/legislate.html>>.

